1. Business Name_____

CASE

EMPLOYER INFORMATION

_____

2. Person to Contact at Business_____ Telephone ( ) _____

Fax No. ( ) _____

3. Street Address_____ Mailing Address _____

_____ (If different) _____

4. City, State, Zip Code_____ _____

5. Nature of Business (provide details of service, product, mfg. process etc.)_____

6. Legal Status: ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ Government Entity ❑ Other_____

7. Standard Industrial Classification (SIC Code) _____ Federal Tax Identification No._____

8. Does your business have more than one location? ❑ Yes ❑ No If YES, list all locations to be covered under this plan.

	Address	City/State/Zip	No. of Employees
Location			
Location			
Location			

9. Are any associated business organizations to be covered? (i.e., parent-subsidiary, brother-sister relationships, affiliated groups, etc.) ❑ Yes ❑ No If YES, complete the following:

Name	Address	Nature of Business	Business Relationship	No. of Employees

ELIGIBILITY

Employees who are actively working on a full-time basis (subject to state requirements) are eligible for coverage.

10. PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE:

A. In the past 12 months, have any employees or dependents applying for coverage been disabled or hospital confined? .☐ ❑ YES ❑ NO

B. In the past 12 months, have any employees not worked full-time due to injury, illness or disability? . . . ❑ YES ❑ NO

C. Are there any employees who are not actively working? . . . . . ❑ YES ❑ NO

If YES to any of the above, please complete the following:

Question	Name	Reason or Condition	Dates From/To	Degree of Recovery/Results

11. Are you subject to continuation of coverage requirements under COBRA? ❑ YES ❑ NO

12. Number of current employees? Full-Time_____ Part-Time_____

A. Number of employees who have worked at least 50% of the working days in the preceding calendar year_____

13. Of the total number of current full-time employees:	Medical	Dental	Life/AD&D	Disability
A. How many are applying for employee coverage?				
B. How many are applying for dependent coverage?				
14. Number of applicants on COBRA/state continuation?				

15. Waiting Period: The length of time future employees must be employed before becoming eligible for insurance:
❑ 30 ❑ 60 ❑ 90 days of employment.

PLAN INFORMATION

16. Requested Effective Date_____ COVERAGE IS NOT EFFECTIVE UNTIL WE NOTIFY YOU IN WRITING.

17. Coverages applying for: **A SIGNED COPY OF THE PROPOSAL MUST BE ATTACHED TO THIS APPLICATION.**

❑ Medical ❑ Dental ❑ Life/AD&D ❑ Disability

18. PPO Network (if applicable)_____

19. Employer Contribution to the premium:

	Medical	**Dental**	**Life/AD&D**	**Disability**
Employee	_____ %	_____ %	_____ %	_____ %
Dependent	_____ %	_____ %		

20. Will this plan replace other group coverage? ❑ YES ❑ NO If YES, complete the following and attach a copy of the most recent billing.

	Medical	Dental	Disability
Prior coverage: Effective Date	_____	_____	_____
Termination Date:	_____	_____	_____

21. Worker's Compensation Carrier_____ Telephone_____

AGREEMENT

The participating employer hereby applies for participation under the Trust sponsored by Time Insurance Company and agrees to be bound by all the terms and conditions of the Group Policy issued to the Trustee policyholder. The participating employer acknowledges that the Trust Agreement and the Group Policy are available for inspection by any person insured through or under the Trust by contacting Time Insurance Company.

I hereby represent as the participating employer or the person acting with the authority of the participating employer, that this information is complete and true to the best of my knowledge and belief. The participating employer fully understands that no insurance will become effective without the approval of Time Insurance Company and that any material falsification or omission may nullify coverage for employees and dependents. It is further understood that no agent has the authority to alter or amend either the Trust Agreement or the Group Policy or to bind Time Insurance Company by making any promise or representation.

The coverages applied for provide benefits for an employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act (ERISA), unless the plan is specifically exempt from the terms of ERISA. For purposes of this agreement, the participating employer acknowledges and accepts full and complete responsibility for the operation, administration, and maintenance of the insurance plan in a prudent and diligent manner in the interest of the plan participants and beneficiaries. Unless this plan is specifically exempted, the participating employer also agrees to comply with the fiduciary, reporting, and filing requirements of ERISA and to act in accordance with the duties and obligations set forth under ERISA, this agreement and any other applicable state or federal laws or regulations.

It is further understood and agreed that: (1) benefits under the Group Policy and the cost of providing those benefits may change; (2) renewal rates will be based on several factors which will include, but will not be limited to the projected future claims experience of the participating employer group, except where prohibited by law; (3) those subject to evidence of insurability must receive prior approval by the Company at its home office before coverage becomes effective; (4) no insurance will become effective until the first full premium has been paid; (5) the cancelled check tendered as the first premium will be a receipt for deposit; (6) the Group Policy may be discontinued by the Company under certain circumstances upon giving proper notice; (7) a minimum of 50% contribution toward the employee cost of insurance is required; (8) only full-time employees and their dependents are eligible; and (9) a minimum of 75% of eligible employees are required to participate in the plan and that insurance may be terminated if the percentage falls below the participation requirements.

Any person who, with intent to defraud or knowing that they are facilitating a fraud against the Company in submitting an application or claim containing a false or deceptive statement, may be guilty of insurance fraud as specified by any applicable State law.

AUTHORIZED SIGNATURE: _____ PRINT NAME:_____

Date:_____ City/State_____ Title:_____

AGENT'S STATEMENT

I certify that all of the information contained in the Employer Agreement and any attached papers is correct to the best of my knowledge. I know nothing unfavorable about this firm or any individual proposed for insurance. I have complied with all of the underwriting rules and have explained the coverage fully.

AGENT'S SIGNATURE:_____ AGENT #_____ Date:_____

Print Agent's Name:_____ Telephone #:_____

Agent's Address:_____ Fax #_____

AGENCY INFORMATION

Name:_____ Agency #:_____

MAILING LOCATIONS

Mail certificates for future employees to: ❑ Agency ❑ Business

Mail New Business Kit to: ❑ Agency ❑ Writing Agent (Please provide mailing address below)

_____

_____

_____

Products are underwritten by Time Insurance Company.